Acknowledgement of Dental Insurance Termination

The Fairfax County Retirement Administration Agency has received a request from you to terminate your dental insurance coverage effective _____ _____. By terminating your coverage with the County you will never be able to re-enroll with any carrier as a Fairfax County retiree. Please complete this form and return it to the following address: 10680 Main Street, Suite 280, Fairfax, VA 22030-3812.

_____ _____

Name (Please Print) Signature

_____

Social Security Number

_____

City, State, Zip